DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
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REPLY TO
ATTENTION OF

MCCS

OTSG/MEDCOM Policy Memo 05-006

22 APR 2005

Expires 22 April 2007

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: AMEDD Behavioral Health (BH) Documentation Policy

1. References:

a. Army Regulation (AR) 40-66, Medical Record Administration and Healthcare Documentation, 20 Jul 04.

b. AR 40-216, Neuropsychiatry and Mental Health, 10 Aug 84.

c. MEDCOM PAM 608-1, Army Family Advocacy Program, 2 Mar 98.

d. Memorandum, HQ MEDCOM, MCIM, 13 Jan 05, subject: Successful Implementation and Use of CHCS II.

e. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards.

2. Purpose: To establish policies and procedures for the documentation and recording of all clinical encounters by behavioral healthcare providers.

3. Proponent: The proponent for this policy is HQ, MEDCOM, Office of the Assistant Chief of Staff for Health Policy and Services, ATTN: MCHO-CL-H.

4. Responsibilities:

a. The Surgeon General has overall responsibility for policy guidance in defining and implementing the Army's behavioral healthcare clinical documentation requirements.

b. The Chief, Behavioral Health Division (BHD), in coordination with the psychiatry, psychology, and social work consultants, is responsible for the distribution of

documentation requirements and reviewing, revising, updating, and deleting existing policies conflicting with these requirements.

c. Military Treatment Facility (MTF) Commanders will ensure all BH clinical encounters are documented in accordance with these requirements.

d. Behavioral healthcare providers will document all clinical encounters in a prompt and timely manner by using the locally determined outpatient medical record documentation systems.

5. Discussion:

a. The medical record, as a rule, should be viewed as patient-centric versus provider-centric. In other words, it exists to promote the welfare of the patient rather than primarily as a convenience to the provider and the involved medical system.

b. Behavioral healthcare is only one aspect of the total provision of healthcare to beneficiaries. Behavioral healthcare must encompass the longitudinal availability and conveyance of relevant behavioral healthcare data for:

(1) Multiple providers including credentialed behavioral healthcare and non-behavioral healthcare clinical providers.

(2) Patient and provider movement secondary to multiple clinical service locations on the same installation and between installations.

(3) Patient and provider movements from installation to installation over time throughout their respective careers.

6. Policy:

a. Documentation of clinical encounters by behavioral healthcare providers will be in the Outpatient Treatment Record (OTR). Behavioral healthcare providers will no longer be required to document clinical encounters in separate outpatient medical records.

b. Legal and administrative information, such as that currently obtained by the Family Advocacy Program (FAP) and Army Substance Abuse Program (ASAP), will continue to be maintained in separate records.

c. Behavioral healthcare providers are defined as psychiatrists, psychologists, social workers, psychiatric and mental health nurses, behavioral science specialists, and psychological assistants. This policy is not applicable to FAP therapists and ASAP counselors.

d. Clinical documentation is defined as the documentation required for the observation, treatment, or care of the patient.

e. Functional data sets with subordinate data categories requiring documentation within the OTR are:

(1) Intake/initial BH evaluation.

(2) Assessment of risk.

(3) Progress note.

(4) Termination note.

7. Procedures:

a. Behavioral healthcare providers should take great care when documenting data domains of significant sensitivity to patients and, hence, support their desire for maximum confidentiality and privacy. These domains include but are not limited to the following areas of concern:

(1) Sexual history/concerns.

(2) Legal history/concerns.

(3) Substance abuse history/concerns.

(4) Financial history/concerns.

(5) Data concerning others.

(a) Family history/concerns.

(b) Relationship history/concerns.

(c) Abuse or trauma history/concerns.

(d) Parenting history/concerns.

(6) Operational/mission-related data.

(7) Psycho-dynamic interpretations/hypotheses.

b. Only information which supports the rendering of an accurate diagnosis and/or aids in constructing a treatment plan and/or assists the provider in rendering a humane and constructive disposition will be documented in the OTR. Concise BH documentation within the OTR supports the continuity of healthcare in collaboration and synchrony with ongoing medical-surgical care across the boundaries of time, space, and varying medical/surgical/behavioral health specialty providers.

8. This policy will be incorporated in the next change to AR 40-66, Medical Record Administration Healthcare and Documentation, and become applicable to:

a. TO&E MTFs, to include Army health clinics and troop medical clinics.

b. Behavioral Health or Mental Health/Hygiene treatment facilities.

c. Field medical units.

d. Dispensaries.

e. Replacement depots.

f. Confinement and correctional facilities.

g. Other Army units in which BH problems are encountered.

FOR THE COMMANDER:

JOSEPH G. WEBB, JR.
Major General
Chief of Staff